

Interjurisdictional Follow-up Form

30 Day Status

☐ Located

☐ Not Located

Return to:

Name:

Fax number:

Address:

Jurisdiction:

Phone number:

Patient Name:

Last, First, Middle

Date of birth:

New Address:

Number Street/Apt. City State Zip Code

New telephone:

Sex

☐ Male

☐ Female

☐ **Case:** (Send RVCT F/U2 to reporting jurisdiction)

☐ Completed:

☐ Moved to:

☐ Died

☐ Lost (after initially located)

☐ Never located

☐ Uncooperative or refused

☐ Not TB

☐ Other

☐ **Suspect:**

☐ Verified by lab

☐ Verified by clinical

☐ Verified by provider

☐ Not verified

☐ Other:

If verified, and original jurisdiction submits RVCT, complete case outcome above.

☐ **Contact:**

☐ No follow-up performed

☐ Never located

☐ Evaluated: ☐ Class II ☐ Class III ☐ Class IV ☐ No infection

☐ Started treatment

☐ Continuing treatment

☐ Other:

☐ **LTBI/Convertor:**

☐ No follow-up performed

☐ Never located

☐ Started treatment

☐ Continuing treatment

☐ Other: .

Comments: